GOVERNMENT OF THE DISTRICT OF COLUMBIA — DEPARTMENT OF HEALTH

SURVEILLANCE MORBIDITY REPORT

HEALTH PROVIDER INFORMATION

REPORT DATE:_____

REPORTING FACILITY	LABORATORY USED	REQUESTING PHYSICIAN
( ) _____ ( ) _____		
TELEPHONE *FAX*	REPORTING OFFICIAL	LOCATION OF HEALTH FACILITY

PATIENT DEMOGRAPHIC INFORMATION

				AGE____
➡ LAST NAME	➡ FIRST NAME	MEDICAL RECORD NUM	➡ DATE OF BIRTH (mo/day/yr)	
➡ NUMBER AND STREET ADDRESS	APT. NUM.	➡ CITY	➡STATE	➡ ZIPCODE

Tel. ( )- Work/Cel. ( )- Emer. Contact - Tel. ( )-

➡ GENDER: ☐ Male ☐ Female RACE: ☐ White ☐ African. Amer. ☐ Asian/Pac. Islander ☐ Amer. Indian ☐ Other/Unknown

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Other

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Is Patient Pregnant? ☐ Yes ____# Wks. ☐ No

PATIENT MEDICAL HISTORY

➡ REASON FOR EXAM: (Chief Complaint, Type of visit , ER, Delivery) _____

➡ DIAGNOSIS ☐ GONORRHEA ☐ CHLAMYDIA ☐ HERPES ☐ SYPHILIS ☐ OTHER: _____

Syphilis Stage - ☐ Primary (Lesion) ☐ Secondary (Rash) ☐ Early Late (< 1yr) ☐ Congenital ☐ Other:

➡ SYMPTOMS

Date of Onset Duration: days Unknown Was patient counseled about partner notification? ☐ Yes ☐ No ☐ Unk.

➡ LABORATORY TEST - Specify Lab Test (Smear, Culture, Urine, DNA Probe, Darkfield, RPR or VDRL, MHA-TP, FTA-ABS, FTA-IgM)

DATE OF TEST	TYPE OF TEST	RESULT
	CHLAMYDIA	**POSITIVE**

➡ TREATMENT (List any previous history of diagnosis/treatment)

DATE OF TREATMENT	MEDICATION/DRUG	DOSAGE

COMMENTS:_____

Is this a non-compliance patient? ____ Yes ____ No

If so, complete all demographic information listed above.

INSTRUCTIONS: ***As a minimum, reports MUST include information marked with an "arrow" ➡ symbol.*** STD reporting requirements are listed in the DC Municipality Regulation, Public Health & Medicine. Upon completion, the information contained in this form must be treated in accordance with Confidentiality Laws. Reports are to be faxed to the Surveillance Unit, Division of STD Control at Fax Number: **202-727-4934**. If mailed, reports should be sent to: **Surveillance Unit, Division of STD Control, 717 14th St., Ste. 750, Washington, D.C. 20005**. Questions regarding reporting criteria and requirements should be addressed to Surveillance Unit at Tel 202-727-6408/9863.

STD Form 050102, Dtd. 2002-05-01